APPENDIX C

PROCEDURES FOR PRIOR AUTHORIZATION OF PSYCHIATRIC SERVICES

Introduction

Prior authorization (PA) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

The purpose of prior authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Prior authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Prior authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Prior authorization is performed by DMAS or by a contracted entity.

General Information Regarding Prior Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for PA requests.

The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the PA entity notifies the individual and the provider in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions, contact names and phone numbers within their organization, information on grievance and appeal processes and questions and answers to frequently asked questions.

The PA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the PA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

APPEALS

Denial of prior authorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the PA denial is for a service that has already been rendered and the issue is whether DMAS will reimburse the provider of the services already provided, the provider may appeal the denial in writing within 30 days of the written notification of denial. Send all written appeals to:

Director, Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS.

Prior Authorization Process for Psychiatric Services

Inpatient Psychiatric Services (Acute Hospitals and Acute Freestanding Hospitals)

Inpatient Acute Psychiatric Services in both acute hospitals and freestanding hospitals require prior authorization. Prior authorization requests for planned/scheduled admissions are required prior to admission. Unplanned/urgent or emergency admissions must be preauthorized within 24 hours of admission, or on the next business day after admission. To request prior authorization, contact KePRO, the DMAS PA contractor. KePRO will accept requests via direct data entry

(DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission can be found at the contractor's website, DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329. The program will take you through the steps needed to receive authorization for service requests.

Outpatient Psychiatric Therapy

Outpatient psychiatric therapy requires prior authorization after 26 sessions in the first year of treatment. During the first year of treatment, there may be an additional 26 sessions when preauthorized. The initial 26 sessions must be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is a limit of 26 sessions in subsequent years, but these sessions must be preauthorized. The 26-visit restriction does not apply to the psychiatric diagnostic interview examination. However, each provider may only bill one psychiatric diagnostic interview examination within a 12-month period. The examination must meet medical necessity criteria.

To check whether authorization is required for additional psychiatric services (the individual has utilized all 26 full initial sessions or all of the sessions subsequently authorized), call the Medicaid HELPLINE at 1-800-552-8627; provide the individual's Medicaid number; and ask for the record of utilization of psychiatric services. The claims history file contains information on paid claims. If a claim has not been paid, the number of available sessions will be overstated. Ask the patient whether he or she has seen another provider; check the records for any services provided but not paid; and ask the HELPLINE whether any other provider is indicated on the file and the last date of service for which a claim was paid.

Claims for services that exceed the sessions available to the individual without authorization will be denied. DMAS is not responsible for claims denied because the service limit has been reached.

To request prior authorization, contact KePRO, the DMAS prior authorization contractor. KePRO will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission may be found at the contractor's website, DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329. The program will take you through the steps needed to receive authorization for service requests.

Psychiatric Residential Treatment (Level C)

Residential Treatment (Level C) requires prior authorization within one business day of admission. To request prior authorization, contact the KePRO, the DMAS prior authorization contractor. KePRO will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission may be found at the contractor's website, DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329. The program will take you through the steps needed to receive authorization for service requests.

Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the recipient. When retroactive eligibility is obtained, the request for authorization should be submitted no later than 30 days from the date notified of Medicaid eligibility.

Treatment Foster Care Case Management

Treatment Foster Care Case Management requires prior authorization within 10 days of admission. To request prior authorization, contact KePRO, the DMAS prior authorization contractor. KePRO will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission may be found at the contractor's website, DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329. The program will take you through the steps needed to receive authorization for service requests.

Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the recipient. When retroactive eligibility is obtained, the request for authorization should be submitted no later than 30 days from the date notified of Medicaid eligibility.

Early Periodic Screening Diagnosis and Treatment

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed

and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the recipient.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or a DMAS-contracted managed care organization as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered and is medically necessary to correct, ameliorate (make better) or maintain the individual's condition. (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

All Medicaid and FAMIS Plus services that are currently preauthorized by the PA contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the individual's condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all pre authorization reviews of prior authorized Medicaid services. Service requests that are part of a community based waiver are the sole exception to this policy. Waivers are exempt from EPSDT criteria because the federal approval for waivers is strictly defined by the state. The waiver program is defined outside the parameters of EPSDT according to regulations for each specific waiver. However, waiver recipients may access EPSDT treatment services when the treatment service is not available as part of the waiver for which they are currently enrolled.

Examples of EPSDT review process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When

the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received 20 individualized counseling sessions and 6 family therapy sessions to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement and other dangerous physical activity, more therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy in a variation or continuation of the current treatment modalities.

The review process as described is to be applied across all non waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non covered services are inclusive of but are not limited to the following services: hearing aids, substance abuse treatment, non waiver personal care, assistive technology, and nursing. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).